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CONTROL OF VENEREAL DISEASE FROM A STATE AND NATIONAL VIEWPOINT*

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Because of lack of funds it has until recently been impossible for state health officers to carry out a complete and satisfactory program for the control of venereal diseases, even though they have been aware that the 1,140,000 people with syphilis who come under treatment for the first time each year offer a serious challenge. Since the passage of the Social Security Act and the recent Venereal Disease Control Act, funds have been made available by the Federal government which are distributed among the various state and local health departments to aid them in their campaign against syphilis and gonorrhea. The Surgeon-General has not only appointed a national advisory committee[1] but has also requested state medical societies to appoint advisory committees to state and local health departments in order to develop an effective program for venereal disease control on forty-eight fronts. It is hoped that there will be close integration and coordination between the local and state and national programs, to include the medical profession, medical schools, local hospitals, research and philanthropic organizations. The problems are to be attacked in the order of their importance with the funds available. Special emphasis on the development of control programs in cities will be made.

Venereal disease control work should be administered by a separate division or by a separate section of the division of communicable disease control. Whether a separate division or section, it should be highly autonomous. The work should be directed by a full-time venereal disease control officer. He should be a person qualified as a health officer who also has had special clinical training in syphilis and gonorrhea.

RECENT PROGRESS

During the year July 1, 1937 to July 1, 1938, progress in venereal disease control work continued. Only 3 states report that they neither maintain nor cooperate in the maintenance of clinics for the treatment of venereal diseases, and some free drugs are furnished in two of the three. In six states syphilis only is treated in the clinics. Free drugs for the treatment of indigent persons with syphilis are furnished in all but two states, and in 14 states free drugs are furnished for all persons of whatever economic status. The treatment of gonorrhea receives less attention, there being only 18 states in which free drugs are furnished for indigent persons, and only 4 in which economic status is not considered. This is an improvement of the previous year when drugs for indigent cases of syphilis were furnished in only 28 states and for gonorrhea in only 12.

Serodiagnostic tests for syphilis and smears for the detection of the gonococcus are done for indigent cases in every state. Smears are examined in all but 8 states for all persons regardless of economic status, while serodiagnostic tests for syphilis are done for all persons in only 8 states. There are 11 states which do not provide for making dark-field examinations.

The number of states reporting a separate division or section of venereal disease control has nearly doubled over the previous year, though there are still 21 states which do not have a separate division. The number of full-time venereal disease control officers has not

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increased, there being 20 states in which a full-time officer is not employed.

The importance of case-finding and case-holding is receiving increased recognition. Only 12 states do not employ workers in this field, and in 3 of the 12 this work is the responsibility of the county boards of health.

That improvement in the performance of serodiagnostic tests is necessary is being recognized more and more. Only 18 states, however, report that laboratories are either licensed or approved by the state and in only 6 of these are all laboratories included; in the others approval is restricted to public laboratories.

Every state and the District of Columbia now has a special venereal disease control law, the Nevada legislature having passed such a law during the past year.

AIMS

The character of treatment facilities should vary with the locality. For cities, clinics should be established, preferably by subsidy of already existing polyclinics. The chief functions of the clinic are (1) to treat patients who are unable to afford private medical care; (2) to diagnose and give emergency treatment to any patient with venereal disease who applies, whether he is a resident or not; (3) to furnish consultation service and give special tests, eg., spinal tests, cardiovascular examinations, to patients referred by private physicians, who cannot afford the private physician's fee for these tests. The subsidized clinics must meet a minimum standard of efficiency and conform to state and national requirements. They should retain full administrative responsibility. Clinics should be conveniently located with separate waiting rooms for men and women. They should have both day and evening sessions so that immediate treatment can be given to early positive cases. Patients should not have to wait too long. Equipment must be adequate. There should be close cooperation between clinics, laboratories and hospitals.

A clinic director should be in charge of each clinic. He should have a large enough staff of social investigators to trace the sources of infection and all contacts of each patient with early syphilis and gonorrhea. Infectious cases which lapse for one week after the scheduled date of treatment should be reported to the health department and investigation should be made by the clinic or health department personnel.

Physicians in clinics and also in private practice should be encouraged to give local prophylactic treatment to patients who present themselves for such treatment soon enough after exposure. The Public Health Service is continuing experimental studies of prophylactic procedures in order to find an effective prophylactic measure for use in the general program.

THE PRIVATE PHYSICIAN'S PART

In localities where no clinics are available, either a clinic should be established if the size of the community warrants, or the cooperation of local physicians must be sought and aid given them so that they may give proper attention to all medically indigent patients with venereal diseases.

In rural communities the work should be carried out with the assistance of local physicians, by properly trained county health officers, by subsidies for the transportation of patients to special treatment centers, or by traveling health units.

It is recommended that each state have at least one venereal disease diagnostic and treatment center in which x-ray and special laboratory facilities are provided. These should have traveling consultation service and provide hospitalization for referred patients. The cost of transporting medically indigent patients for these services should be borne by the state. The state health department may designate one or more physicians as traveling consultants.

DIAGNOSTIC MEASURES

The state laboratory should set standards for the performance of serologic tests. There should be a system of state approval or licensure for hospital, institutional and private laboratories. Each laboratory should have a competent director and an experienced technical personnel. There should be close adherence to accepted standards of maintenance of glassware, animal material, reagents, and equipment. Periodic performance of interlaboratory cross-checks on identical specimens and periodic clinical control of serologic results by means of cross-checks against the

diagnoses made at efficient syphilis clinics should be conducted under state or other expert auspices.

The following principles should apply to the details of serodiagnostic procedure. The recommendations promulgated by the Committee on Evaluation of Serodiagnostic Tests for Syphilis should be drawn up and supplied in memorandum form to all clinics and laboratories interested in the control of syphilis. Standards for handling specimens and equipment should be drawn up and published with the assistance of the Public Health Service. The technic of the originators of tests should be strictly followed by all laboratories, and modifications, if introduced, should be approved by the central state laboratory authority. Laboratories should be required to use the terms "positive" and "negative" and "doubtful" (indeterminate-repeat) in reporting the results of qualitative serodiagnostic tests. Finally, it should be made clear that while a single test may be used in a laboratory as a first line diagnostic procedure, the adequate serologic investigation of a doubtful or indeterminate result requires not only repetition of the original test but also the simultaneous use of another test of a different type.

No less than a Gram stain or a good modification thereof should be relied upon for the laboratory diagnosis of gonorrhea. The use of cultures is desirable.

Treatment and Control

The plan of therapy to be followed for patients with syphilis of less than 5 years' duration is that of continuous treatment as advocated by the Cooperative Clinical Group[2]. The minimum standards for latent syphilis (of 5 or more years' duration) and for syphilis in pregnancy, as outlined by the Cooperative Clinical Group, should be utilized. Spinal tests should be made on all patients, eg., in the second 6 months of treatment for early cases and on admission for late cases. A thorough cardiovascular examination should be made at some time on all patients. Complete records of each case are to be kept.

In one of the earliest reports of the Cooperative Clinical Group[3], 339 cases of mucocutaneous relapse are reported among a group of 2340 patients who had been under observation or treatment for 6 months or more[4]. Of 339 cases of mucocutaneous relapse for which the time interval from onset of infection was known, 25.7 per cent relapsed in the first 6 months of the infection and 29.2 per cent in the second 6 months, a total of 54.9 per cent within the first year. By the end of the second year after infection 84.7 per cent had relapsed. In relation to treatment, 45 per cent of the relapses had occurred within 6 months after treatment ceased; by the end of the first year, 73.6 per cent; and by the end of the second year, 91 per cent. Patients who had received only 1 to 4 doses of arsphenamine showed 64 per cent relapses, whereas those who had received 5 to 9 doses of arsphenamine had 14 per cent relapses. These observations indicate that prevention of relapse can be accomplished by prolongation of treatment, particularly with arsphenamine. The Cooperative Clinical Group was able to obtain satisfactory results by the administration of continuous-alternating treatment in 64 to 86 per cent of patients with early syphilis.

According to other findings of the Cooperative Clinical Group[4], 91 per cent of children will be born healthy if the syphilitic mother receives adequate treatment instituted before the fifth month.

Case Finding and Case Holding

As an aid to both physician and patient in the carrying out of an effective venereal disease control program, the role of the follow-up worker is an extremely important one[5]. This work includes the tracing of sources of infection and contacts, attendance supervision, prenatal supervision, arranging for the transfer of patients from one clinic or physician to another, and education by direct contact, through lectures, and by other means.

Choice of well qualified personnel in the epidemiologic field is absolutely necessary. The workers should be tolerant, tactful, sympathetic and should have a real desire to understand people and to help them. They should have a broad general education, be acquainted with psychology and have a special knowledge of venereal diseases, particularly from the public health point of view.

Every patient should be referred to the follow-up worker on his first visit to the clinic, immediately after the physician has seen him.

The first interviews are important for tracing sources of infection and contacts, for discovering personal problems, and to establish the proper rapport between the patient and the clinic. Printed instructions may be given him at the first meeting.

The name of each patient should be listed in a follow-up file by a clerk whose duty it is to notify the follow-up worker of lapsed attendance. Within a week of lapsed attendance a visit should be made to the patient if this is possible, since a much better contact is established with the patient through visits than with follow-up letters. A report of the reason for delinquency and the action taken by the epidemiologic worker should be given to the physician who is responsible for the case. Patients in an infectious stage who refuse to take treatment or who are mentally incapable of understanding the reasons for doing so should be reported to the law enforcement agents only after a review of the history by the examining physician and upon his authority. An attempt should be made to follow uncooperative patients, who leave the city for a known destination, by reporting all available medical and social information to the responsible health authoriites of the city to which they have moved.

The follow-up worker should make special effort to keep all syphilitic pregnant women and their children under treatment as long as necessary. She should aid the physician in family investigation in cases of late syphilis and in gonorrhea.

The importance of follow-up work is indicated by the report of Smith[6], which states that in 1930-1934, with special intensive follow-up work at the University of Virginia clinic, 41.2 per cent of patients with early syphilis returned for the minimum standard of antisyphilitic treatment. It will be remembered that according to the Cooperative Clinical Group report only 16 per cent of patients with early syphilis continue treatment until they are permanently non infectious.

UNDERGRADUATE AND POSTGRADUATE MEDICAL TRAINING

In the informative program for physicians, undergraduate training is of the greatest importance. A study of the status of problems of venereal disease teaching in each individual medical school of the United States may be worth while. Certainly a minimum curriculum in medical schools for the teaching of venereal disease control should be recommended. Division may be made between required and elective courses. The required courses should consider general methods and interpretations, control of infectiousness, standard diagnosis and treatment of early and latent syphilis, the general management of late syphilis, prevention of cardiovascular, prenatal and neurosyphilis, the use of drugs with precise instruction in the details of technic and emphasis on indications, reactions, and contra-indications. The detailed consideration of rarer lesions, intricate (consultant) problems, and the relation of syphilis to the specialties may be left to the elective courses[7]. Similar attention should be given to gonorrhea and other venereal diseases.

Next to better instruction of medical students, postgraduate instruction is of great importance. This should include short review courses in current diagnostic and treatment practice and the prolonged intensive training in venereology for the specialist. For the former, the state health authorities are urged to take the necessary measures in their own states,. The Public Health Service assists in the latter by providing for formal training in a number of medical schools throughout the country. There is also an instruction center under the direct supervision of the Public Health Service at Hot Springs, Arkansas.

Circulation of the monthly journal *Venereal Disease Information*, released by the Public Health Service, has proved to be of value in furnishing physicians with information to aid them in practice and in securing their active cooperation in the public health control of venereal diseases. The circulation of this journal, now having the largest paid subscription list of any Federal publication, will be increased as far as possible. Supplements to this publication are distributed to physicians from time to time.

TEACHING THE PUBLIC

In the public education program, special lay groups should receive attention, as, for example, the tuberculosis and health societies, child hygiene organizations, social agencies, business clubs, parent-teachers' and women's

clubs. They should be told frankly what is needed. The health authorities should use their power and prestige to obtain the adoption of an effective policy by large industries and life insurance organizations.

The education of the public in general should be carried out through the media of the radio, the press, motion pictures, pamphlets and posters, lectures and exhibits. Particular attention should be given to special groups, such as, single persons, groups of young people, and pregnant women. Educational authorities should be urged to develop programs for proper teaching of subjects pertaining to biology.

Requests for routine physical examinations including blood tests for syphilis should be encouraged. It should be pointed out that venereal diseases may exist without the infected person's knowledge; that about 1 syphilitic man in every 5 and 1 syphilitic woman in every 3 have syphilis without being aware of it. The public should be informed of the importance of routine blood tests at least once and preferably twice during each pregnancy. It should be made aware of the ravages of congenital syphilis and of the fact that with proper antisyphilitic treatment during pregnancy these infections can nearly always be prevented. The routine serologic test for syphilis should be introduced in every department of all hospitals. Every effort should be made to convince all groups—physicians, social agencies, the general public—that syphilis is merely one of the infectious diseases and not the just consequence of an immoral life. Many patients today do not seek help for this disease, even though they know or suspect that they have it, because they are ashamed of it or because they fear the censure of public opinion.

Teaching proper facts to the person who has become infected with a venereal disease is of the greatest importance. There are three chief essentials in the treatment and control of venereal disease from the public health point of view: (1) To get the infected person under treatment as soon as possible; (2) to keep him from infecting others; (3) to keep him under treatment until he is permanently non infectious. In order to accomplish this, the education of the patient is of the utmost importance. The factors which tend to discourage patients and cause them to discontinue antisyphilitic treatment are the length of time required for adequate treatment, the cost, inconvenience, fear of public opinion, reaction to treatment, and failure to understand the seriousness of the disease as well as the importance of long continued treatment to the ultimate outcome. For these reasons patients should be treated with a great deal of patience and sympathy by physicians, nurses and social service workers. Exner[8] studied two clinic groups at Bellevue Hospital, one instructed and one not instructed. The average number of treatments was 26.2 for the instructed group as compared with 16.9 for the non-instructed group. According to the findings of the Cooperative Clinical Group, 84 per cent of patients with early syphilis discontinue treatment before they are permanently noninfectious.

Mechanical System of Reporting

In an evaluation of a program for venereal disease control the regular collection and constant study of morbidity reports should be fundamental. A mechanical system[9] of reporting treatment, progress, and control of venereal diseases has been devised by the Public Health Service. With this system the private physician, the clinic director, and the health officer can obtain a current monthly report on the following: (1) treatment status of individuals in the infectious stage of the disease; (2) the number of individuals who interrupt the treatment schedules before obtaining maximum benefits from treatment; (3) the extent to which continuity in treatment schedules is maintained through an effective transfer procedure; (4) the success of the treatment source in obtaining a "cure" for individuals with venereal disease; (5) the effectiveness of a program for prenatal care of mothers with syphilis; (6) a means of follow-up and treatment of newborn children of parents with syphilis; (7) epidemiologic work measured in terms of contacts brought under treatment.

The operating procedure for the mechanical system of reporting is briefly the following: A central tabulating unit is established by the state or local board of health. This unit tabulates, mechanically, data submitted

by all authorized treatment sources and summarizes them as monthly venereal disease treatment-progress and control reports. All participating treatment sources, including physicians in private practice, receive an individual report on their particular activities for the month.

SUMMARY

1. The recent progress which has been made in the control of the venereal diseases is described.

2. Immediate aims are enumerated and a practical method for developing treatment facilities outlined.

3. Steps necessary for the prosecution of effective laboratory work are defined.

4. There is a discussion of the important points in case-finding and case-holding work.

5. Comments are made upon the importance of undergraduate and postgraduate training and public education in the venereal disease control campaign.

6. A mechanical system is described for reporting cases in order to measure future progress.

REFERENCES

1. Vonderlehr, R. A. et al.: Recommendations for a Venereal Disease Control Program in State and Local Health Departments; Supp. No. 2 to Ven. Dis. Inform., Washington, Gov't. Printing Off., 1936, p. 1.
2. Stokes, J. H., et al: Cooperative Clinical Studies in the Treatment of Syphilis—Early Syphilis; Ven. Dis. Inform., Washington, 13: 165, 207, 253; 1932. Cooperative Clinical Studies in the Treatment of Syphilis—Latent Syphilis; Ibid., pp. 317, 351, 371, 389, 407.
3. Stokes, J. H., et al: Cutaneous and Mucosal Relapse in Early Syphilis and Its Differentiation from Reinfection; Ven. Dis. Inform., Washington, 12: 55; 1931.
4. Vonderlehr, R. A.: The Control of Syphilis with Special Emphasis on Adequate Treatment as a Control Measure; Ven. Dis. Inform., Washington, 16: 413; 1935.
5. Waters, L. R.: Ingraham, L. B.: The Organization and Function of Follow-up Service in Venereal Disease Clinics; Ven. Dis. Inform., Washington, 19: 220; 1938.
6. Smith, D. C.: Practical Epidemiology of Syphilis—The Control of Syphilis. Supp. No. 2 to Ven. Dis. Inform., Washington, 1936, p. 35.
7. Stokes, J. H.: Education of the Physician and the Movement for Venereal Disease Control; Ibid. p. 50.
8. Exner, M. J.: The Value of Instructing the Syphilis Patient; Ven. Dis. Inform., Washington, 16: 59; 1935.
9. Usilton, L. J.: A Tentative Mechanical System for Reporting Morbidity, Treatment-progress, and Control of Venereal Diseases. Washington, U. S. Public Health Service, 1938 (mimeographed).

DISCUSSION

DR. I. L. CHIPMAN (Wilmington): I enjoyed Dr. Vonderlehr's paper and slides. I think we have set up in our state one of the best organized controls that can be found, because of the fact that we are a small state. Our clinics here are geographically well placed and are properly supervised by Dr. Jost's staff and the nurses are doing the follow-up work, and every one is doing a great job in spreading propaganda.

Just to show you that: last year there was an increase of forty-three per cent of new cases of syphilis in the state of Delaware. Only a few years ago there was possibly only one or two per cent. This year there has been an increase of eighty-three per cent in the number of treatments. So you see the propaganda that is going on and the work that is being done in all of the states will eventually react as far as the taxpayers are concerned. It will prevent these cases from entering our insane asylums. It will prevent the late sequelae of syphilis; and eventually, to my mind, as far as the general practitioner is concerned, he will gain by the work that is being done.

As I see it, I think these slides have explained the work that should be done, and we as physicians, should encourage and get back of this movement.

DR. J. C. BECK (Dover): I appreciate Dr. Vonderlehr's coming here and telling us what is being done in other parts of the country. We certainly know that the paper he presented was a fine one.

One of the slides indicated that Delaware has a part-time venereal disease control officer. When we sent the information in to Washington that was true, in the sense that we have no separate division of venereal disease control, but it is part of the division of communicable disease control. However, we have a man now who devotes his entire time to venereal disease work. We have follow-up nurses in each county and in Wilmington, and as the figures that Dr. Chipman gave you show, they are accomplishing results, as evidenced by the increased number of treatments that have been given, 83 per cent, and as compared to the increased number of cases, 43 per cent, reported.

The work will continue. We are hoping that Congress will see fit to see that Delaware is subsidized in the future through the Public Health Service.

PRESIDENT PRICKETT: At this time I would like to introduce a guest, Captain Richmond C. Holcombe, Assistant Surgeon-General, United States Navy, Retired. He might like to say a few words on the subject.

Captain Richmond C. Holcombe (Upper Darby, Pa.): Mr. President, Members of the Society: When an officer of the Navy reaches the age of sixty-four, he is officially dead, so you may consider what I have to say as a voice from the grave.

I have always been interested in syphilis, for a long number of years. When the war broke out I found myself shoved onto the Venereal Disease Committee of the Council of National Defense, although my interest in it dated long before that. It has never flagged since that time.

The shades of the dead would probably look back and remind you that it was not very many years ago, not a decade ago, when nobody spoke the word "syphilis" aloud. It was spoken in whispers because there was a campaign of silence in that matter. What we needed was some man who would have the courage to say that word aloud. There was a man who happened at that time to be the Commissioner of Health of the Empire State, who attempted to speak over the radio. He mentioned this disease as one of the diseases which confronted health officers, with the result that any talk by him was censored. It was repeated even when Dr. Rice attempted to speak of his budget in the City of New York itself.

Gentlemen, we have emerged from that campaign of silence and we have seen some very startling things announced. I won't mention the names of books. There is one which has the title, "Shadow on the Land." There is another entitled "Ten Million Americans Have It." And if ten million Americans have it, it sounds to me very much as if there might be something in the nature of an epidemic.

What we need is leadership. If there is any country anywhere where those in charge of public health are interested and have the courage to take up the torch and lead us on, and if these things like "Ten Million Americans have it," really exist, then it behooves us of the medical profession to get behind those men.

I think you were fortunate today. Dr. Vonderlehr is one of the field marshals of this movement, and a very important field marshal, too. He has talked to you in a very dignified manner of the problem as he sees it, what the states should do, and he has placed the responsibility largely upon the states in this matter.

I don't know how old this disease is. Personally, I believe there was a large epidemic that spread all over the Roman Empire around the time of Christ, and it was pretty well under way certainly by the year 76. I believe also that there was a very large epidemic of it at the time that the Lombards swept over Italy. I believe there was another epidemic and a much more serious epidemic that swept through France after the Crusades. I know that when the guilds first came into existence and the different guilds began to set up their rules there was plenty of evidence in the rules of the barbers, the seamstresses and the butchers that there was a disease which I will call a syphiloid. We know that there are syphiloids today. We know that in Mesopotamia, and in Hertzia and Bosnia there is a type of syphilis which affects children principally. We know the same thing exists under different names in different parts of the world. One of the names is yaws, another is bouchat. We know that these syphiloids appear again and again and that we are confronted with a very serious problem which has lasted an extremely long time. That, gentlemen, is my own private opinion.

And now, if I may step back into life again I want to say that I have appreciated being here very much and having seen the slides and having heard the Assistant Surgeon-General of the Public Health Service make this presentation. My prayers are with him and I hope that he will have all success in this campaign.

Dr. Victor D. Washburn (Wilmington): I have enjoyed the remarks of the Assistant Surgeon-General, and I rise to my feet only to make one or two points.

I am sure that Dr. Chipman in his remarks did not mean that there had been an increase in the number of cases to the extent of 43 per cent in syphilis, but that there had been a 43 per cent increase in the number reported.

Dr. Beck: That is right.

Dr. Washburn: There is a difference.

I wish also to speak of the fact that in 1936 there were reported to the Delaware State

Board of Health I think 542 new cases of gonorrhea, or some figure similar to that, at least, and that in the same period of time there were 1506 new cases of syphilis reported. Obviously, since the experience everywhere is that there is a very much larger number reported or infected with gonorrhea than with syphilis, it appears that we in Delaware were delinquent—I would put it this way: we, the members of the medical profession, were delinquent in reporting our new cases of gonorrhea. It seems to me that that must be so.

I speak of that at this point because it would appear that we owe it to ourselves to cooperate to the fullest extent with the State Board of Health in its attempt to control both syphilis and gonorrhea, that we may have accurate bookkeeping methods so that when the time comes when we will be called on to account for the money spent and the effort put out we can say that we have accomplished something in the reduction of the actual number of cases, or that we have not, and be governed thereby in our methods of treatment and control.

I wish to speak of one other point, Mr. President, that is, that those persons presenting themselves to our offices with some sort of open lesion on the genitals should not be treated with local applications of medication of any sort until someone, either ourselves or the persons to whom we wish to refer the patient, or the State Board of Health, has had the opportunity of determining whether or not the lesion is a primary lesion of syphilis. It is almost instinctive on the part of the patient to demand some sort of topical application, and it is almost equally instinctive on the part of the physician to apply some medication because the patient comes to be treated. We all know that these medicaments applied either take from us the opportunity of making a darkfield examination, or at least delay it. You must all remember that if the patient who has been so unfortunate as to contract syphilis can be found in that primary stage, the results in patients so diagnosed and so brought into adequate treatment are excellent. I think that ninety-five per cent of them can be brought to a cure, and within a matter of months. This is our responsibility as practitioners of medicine. And to the extent that we observe this detail and report our cases, the sooner may the time come when Dr. Tarumianz and his staff will approach that stage of technological unemployment which Dr. Chipman points out—maybe we won't have as many people up there in that institution.

DR. M. A. TARUMIANZ (Farnhurst): Mr. President, I didn't intend to say a word, but since Dr. Washburn mentioned the State Hospital, corroborating Dr. Chipman's statement, I would like to say that we are all proud of Dr. Parran who was as courageous as possibly an angel and attempted to do something that no one else has ever attempted in this country. But we must also be proud of our President. Never in the history of the Medical Society of Delaware has a Presidential address concerned itself with sex instruction in the schools of Delaware. That is something that we should consider again as a new step in our medical educational phase of life.

As to syphilis, I have always tried to lecture on the subject for the last twenty years in the state of Delaware, basing my experience on the fact that syphilis is not such a terrible disease. It is really one of the most easily cured diseases that I know of if one knows how to treat it and knows how to continue treating it until the disease is eradicated. Obviously, then, if we educate our people to the fact that syphilis is not such a dangerous disease as it has been accepted to be for centuries, since now we know the cause and the specific treatment for it, people will not look upon syphilis as something absolutely doomed or an impossible situation.

May I also state that it will take about twenty years to eradicate the syphilitic cases or neuro-syphilitic cases from state hospitals? So, having passed the half century, I should not worry about my unemployment. (Laughter) I am sure, or I hope at least, that I will not be practicing medicine in twenty years. In the last twenty years there has not been a great change in the number of admissions of neuro-syphilitic cases in state hospitals. They have been twelve to fifteen per cent of all newly admitted cases. It will take at least fifteen or twenty years until we see the result of this approach.

DR. T. E. HYNSON (Smyrna): Mr. President, there is just one thing I would like to

add to this: we in the State Board of Health are primarily interested in seeing that these cases of syphilis and other venereal disease receive treatment. As long as a case is actually receiving treatment, regular treatment, from a physician, that is our only interest. But if he becomes delinquent then we need to step in. That is where we can help you in keeping your cases under treatment.

We are asking you—we have asked you before—to do this: when a case becomes delinquent, let us know about it if you are unable to return it to treatment yourself. We have facilities to get the majority of them back either to you or to some other source. We will do our best to return them to you. We will try to find out what the trouble is. If it is financial then some arrangement may possibly be made whereby they can secure treatment. If you will report your delinquent cases to us you will then give us a chance to do our share of the work.

THE EVOLUTIONARY PERSPECTIVE OF SYPHILIS (Abstract)

Capt. R. C. Holcomb, M. C., U. S. N.
Upper Darby, Pa.

At a joint meeting of the Sussex and Kent County Medical Societies, held at the Caulk Auditorium, Milford, Delaware, March 1, 1939, an address, illustrated with lantern slides, was given by Captain R. C. Holcomb, M. C., U. S. Navy, retired, on the Evolutionary Perspective of Syphilis.

After a few words illustrating how the concept of the disease had changed during the past 100 years, the balance of the talk was presented with lantern slides. One hundred years before he had graduated in 1896, gonorrhoea, chancroid and syphilis were all considered to be one disease. About nine years after his graduation, Schaudin and Hoffmann discovered the spirochete, then cardio-vascular and neuro-syphilis were established upon acceptable and undisputed grounds. Today syphilis has suddenly emerged out of a conspiracy of silence to be one of the most popular of diseases. One writer announces ten million Americans have it. Surgeon - General Parran and his statisticians have announced that of every person born alive in the United States, one out of every ten will have acquired syphilis before the fiftieth year of life. It appears there are three reasons why the average physician will never be able to confirm this probability, and furthermore, this startling "guesstimate" is based largely on a modern phenomenon of the mysterious behavior of a reagin-globulin with lipoid particles, and popularly called a "Wassermann test."

Among the slides shown was an ancient text from the incunabulae, published in 1491, with a description of venereal leprosy by Bernard de Gordon who wrote in 1308, and in which text was described all the venereal methods of transmission adopted later to describe *morbus gallicus* (the French disease). Gordon illustrated the venereal transmission with the case of a Countess with leprosy who applied to him for treatment at Montpelier. He turned her case over to a Batchellor of Medicine to carry out the treatment. This Batchellor shared his bed with the Countess, and, says Bernardus, she became pregnant and he contracted her leprosy. Then to show that this leprosy had the pathological characters of syphilis, lantern-slides of skulls from leper cemeteries of the Middle Ages were shown, which were recovered from an ancient cemetery in Paris by Lancereaux, and which were identified by Professor H. U. Williams, to be surely syphilitic. These leper skulls were followed by slides of syphilitic skulls from the Mutter Museum in Philadelphia, and from the National Museum at Washington, D. C., showing the identical pathology in tertian or late syphilis.

Next, from the incunabulae of 1490 (prior to the discovery of America), slides were shown from the work of William of Salicet dealing with *pustulis*. Both the primary sore and the later eruption are described under this name, and William as well as others of his time (1275 A. D.), calls it a first sign of leprosy. The word "syphilis" was not invented by Fracastoro in his Virgilisque poem, until 1530. The primary sore is described as following intercourse with a prostitute or a filthy woman. This same text, which is dated June 1275, contains a description of venereal prophylaxis to be used after a suspicious intercourse. Many other texts of the Middle Ages, which however did not get into print until later, contain this same direction as to

prophylactic measures, not only for men, but for women also.

With the aid of lantern slides and other exhibits, Dr. Holcomb then showed how the various methods of transmission for this venereal leprosy of the text of Bernardus and others was transferred *en bloc* to *morbus gallicus,* a name invented by Leonicensus and his people to express a war hatred, which later became *lues venera,* or venereal pest, and then when gonorrhoea was shown to be a distinct disease, the word syphilis, utterly meaningless, came into use because some distinction was necessary.

Then with a series of slides he traced the origin of the Haitian myth of the American origin of syphilis. This myth of the American origin of syphilis arose fully 30 years after the discovery of the New World and was based on the belief that guaiacum (called the Holy Wood), was a specific for syphilis, a view that prevailed for over 150 years. Its common name, the Holy Wood, was based on a tenet of faith put forward by many Spanish writers, that Divine Providence provides the remedy for a disease at the place where that disease originates. As the Holy Wood came from the West Indies, it followed that the disease also originated there.

The second part of Dr. Holcomb's talk was devoted to showing how syphilis of the Middle Ages still flourishes today among widely dispersed peoples living under unsanitary conditions of personal hygiene, and who are without the means of adequate specific treatment. After showing some pictures of life in a walled city of China as he observed these conditions in 1899, in order to illustrate the unsanitary conditions of the Middle Ages, he exhibited a number of slides illustrating the disease called yaws as seen in such places as the Philippines, Samoa, Guam and the West Indies, and where during the past 40 years, U. S. Naval Medical Officers have had a unique clinical and pathological experience. Time has shown that the infection of yaws results from the spirochete which is undistinguishable from that found in syphilis. The same sort of lesions as encountered in syphilis are found in the bones, liver, adrenals, testicles, aorta and brain. Yaws in the tropics is precocious syphilis, and is, because of the ease of its transmission here, usually a disease of childhood. It begins as a primary lesion called "mama-yaw," and is shortly afterwards followed by a secondary eruption. Sleeping upon straw mats often encrusted with the secretions and discharges of the infected, their exposed bodies invite infection, as does also swarming flies, the common use of utensils as well as other common native practices. With the advent of the secondary eruption, the spirochete working *from within,* these same habits and practices, under the favorable conditions of climate invite a superinfection *from without* by the liquifying bacteria inhabiting their unwashed skins. In the light of modern bacterial knowledge it is not so hard to understand how these pustular eruptions occur as it would be to explain an immunity to them. Without adequate treatment in a small proportion, the infection may advance to a frightful disfiguring tertiary lesion, involving the bones of the face and skull, recently named gangosa, and which is very frequently described in classical as well as ancient medical texts as confirmed leprosy. Many slides were shown to illustrate this condition, not only from the United States possessions, but also along the southern litoral of the Mediterranean basin. Such bones as the tibia and ulna are also frequently involved. A description of practically all the lesions of yaws are to be found in incunabulae—those texts printed before the year of 1500—right after the invention of printing came into existence, an art that did so much to advance knowledge.

The pathology as found in 1768 autopsies at Haiti was discussed, and illustrated by slides showing clinical cases, gross pathology, micro-photographic specimens of lesions, as well as the parasite itself in the lesion, the two latter slides from the splendid work of Professor Carl Weller, of the University of Michigan, upon material collected at Haiti by Chambers of the Navy.

In conclusion, slides were shown of cases of gangosa before and after treatment with the arsenicals, mercury and the iodides. This treatment with salvarsan was begun in some of the island possessions about 1911. As happened with syphilis, the marvelous results at first seemed to show that a single dose was specific, but after less than one year of ex-

perience with this drug it was shown in this disease also a more prolonged course was necessary.

Closing his talk, which was illustrated by 46 lantern slides, Dr. Holcomb offered the following postulates:

1. The notion that European and Asiatic syphilis originated in Haiti or in America is a myth.

2. All the lesions of modern treponematosis called syphilis or yaws, are to be found in the circumstantial descriptions of the surgeons of the Middle Ages under a variety of names.

3. In the more advanced scientific considerations there is an undistinguishable likeness in the parasitic cause, methods of infection, symptoms, course and stages of the disease, gross lesions, microscopic pathology, serology, and response to identical therapy as between yaws and syphilis.

4. Yaws is a form of syphilis, often untreated, among a people ignorant of and not practicing the elementary principles of personal hygiene, for which reason it is frequently transmitted in childhood, and is only occasionally venereal.

5. The syphilis of antiquity was largely of the character of yaws as it is seen today among unprotected peoples.

306 S. Madison Avenue.

DELAWARE ACADEMY OF MEDICINE

Officers and chairmen of committees who assumed office this month are:

President, Dr. Lewis B. Flinn; first vice president, Dr. Willard F. Preston; second vice president, Dr. John C. Pierson; secretary, Dr. John H. Mullin; treasurer, Dr. W. H. Kraemer; chairman library committee, Dr. I. M. Flinn, Jr.; chairman scientific committee, Dr. O. S. Allen; chairman admission committee, Dr. J. D. Niles; representative of the Medical Society of Delaware, Dr. W. O. LaMotte; representative of the Homeopathic Medical Society, Dr. V. D. Washburn; and representative of the Delaware State Dental Society, Dr. E. E. Veasey.

Mr. Walter E. Jackson, custodian of the Delaware Academy of Medicine building since 1933, died of heart disease at his home in Wilmington, on March 21, after an illness of three months. He was born 63 years ago in Talbot county, Maryland, and previous to coming to Wilmington had resided in Harrisburg and Baltimore. His wife, Mrs. Estelle C. Jackson, is his only survivor.

Mr. Jackson was a familiar figure to all physicians and dentists attending meetings at the Academy, and will long be remembered for the cheerful cooperation he always gave to all activities that were to the best interests of the Academy, and the societies. He knew a saying, or proverb, suitable for nearly every occasion. On one of his last visits to the library, when thanked by the Librarian for some service he had given, quoted:

"I am passing through this world but once;
Therefore, if there is any good I can do
Or any kindness I can show
I should not put it off—
For I shall not pass this way again."

Such was the philosophy and character of "General" Jackson, good man and Mason, an institution in himself, and those who knew him best will regret the most that he "shall not pass this way again."

MAY DAY—CHILD HEALTH DAY

Monday, May 1

Child Health Day activities are sponsored by the Childrens' Bureau, in accordance with the Congressional Resolution of May 18, 1928, which authorized the President to proclaim May Day as Child Health Day.

Slogan—The health of the child is the power of the nation.

Objective—To bring to the attention of each community—

The importance to the child's health, development, and well-being throughout life, of proper food, rest, exercise, medical care, and protection against disease.

The ways of informing parents and others how child health may be safeguarded, and

The means whereby such safeguards may be made available for all children.

May Day chairmen and representative May Day committees have been appointed by the State Health Department. The Departments of Education will cooperate in planning school Child Health Day programs. For details of state program write to May Day chairman, Department of Health, Dover.

THE CANCER CAMPAIGN

The Delaware branch of the Women's Field Army of the American Society for the Control of Cancer will conduct their drive for funds April 24th to 29th inclusive. They ask for a modest amount of money to carry on the operating expenses of the Delaware committee, the object being more the securing of interest than of a large amount of money.

The women are headed by Mrs. William H. Beacom and her adjutant, Mrs. Thomas Young. Other interested women throughout the state will assist. Mrs. Ava Watson, librarian at the Delaware Academy of Medicine is secretary, and is in a position to answer inquirers and visitors regarding the work.

The members of the medical profession also have rendered very effective service by talking before lay groups throughout the state. These services, of course, have been rendered without compensation and without expense charges for automobile use. This has been no small item, because distances in the lower counties have been considerable at times. Through such talks several hundred people have been reached, and information regarding cancer is believed to be having a good effect in earlier attention to the care of suspicious growths, and also in an increased interest in a general physical check up by many persons.

ANNOUNCEMENT

The officers of the International College of Surgeons announce their forthcoming International Assembly which will be held at the Roosevelt Hotel, New York City, May 21-25, 1939.

Surgeons are invited to attend.

Fred H. Albee, M. D., program chairman, 57 W. 57th street, New York City.

Chas. H. Arnold, M. D., secretary to Scientific Assembly, Lincoln, Nebraska.

If interested in space for scientific exhibits apply to Edw. Frankel Jr., M. D., chairman of arrangements, and executive secretary of U. S. Chapter, 217 E. 17th street, New York City.

DR. MORRIS TO LEAVE

Doctor Woodbridge E. Morris, director of the Division of Maternal and Child Health and of the Crippled Children's Service of the State Board of Health, will leave Delaware May 1st to take a post directing the Birth Control Federation of America, with headquarters in New York.

Doctor Morris has served Delaware in his present capacity since April 1936. He was brought here under Social Security Act appropriations to the state health services which he directs. During this period he organized the state crippled children's service. The maternal and infant death rates have both touched new low points. Finding widespread malnutrition among the school children, he also instituted a State Health Department nutrition service. Most of his work has been based on the principle that the public health could be expected to improve only with increased public health intelligence.

To reduce the number of needless maternal and infant deaths he has endeavored, through the nursing staff, to locate expectant mothers, get them under the care of a physician, and help them to prepare themselves and their homes for the coming of the child. To supplement this, regular instruction and supervision of midwives was intensified; they were given physical examinations, and many of the unfit ones were deprived of their license. Believing in the importance of the individual patient-physician relationship, he has opened no prenatal clinics in Delaware.

In 1937, at his request, the Medical Society of Delaware formed a special Committee on Maternal and Infant Mortality, which instituted a cumulative study of the causes of maternal deaths.

He is State Child Health Day chairman, a director of the Delaware Anti-Tuberculosis Society, vice-chairman of the Kent-Sussex chapter of the Social Welfare League, a member of the N. Y. A. advisory committee, of the state medical society committee on sex education, of the Kent County Medical Society, Delaware Health Council, and Dover Kiwanis Club.

Dr. Morris was born in Connecticut in 1902. He received his A. B. at Yale in 1923; his

(*Concluded on Page* 68)

EDITORIAL

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Local news of possible interest to the medical profession, notes on removals, changes in address, births, deaths and weddings will be gratefully received.

All advertisements are received subject to the approval of the Council on Pharmacy and Chemistry of the American Medical Association.

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Vol. XI April, 1939 No. 4

The Wagner Health Bill

At last the national health bill, prepared by Senator Wagner, has seen the daylight. Congress has it.

Instructed by the Interdepartmental Committee through its conferences and the various addresses of its chairman, as well as through sundry press releases, as to what the national health program entails, we thought that the propositions the program embraces would be reflected in the bill which Senator Wagner was so long in preparing.

The bill is the epitome of vagueness. It leaves the control of medical practice to the supervision of lay political bureau chiefs. It indicates that they *may* have advisory medical boards, but it does not provide that these lay chiefs must take the advice of such boards, nor does it show how such boards are to be brought into being, or what type and kind of man shall serve on them.

Departments of the Federal government have a voice in the distribution of funds, which are held out to states to lure them into experimentation on ways and means of delivering medical care to the low income earning groups and to the indigents. The Children's Bureau, the Department of Labor, the Public Health Service, the Social Security Board, and their departmental chiefs, are each and all interested in this particular part of the propositions, and, in the main, the act would function under them.

The bill evidences a total lack of any provision for establishing adequate medical standards, and it seems to make the state health officer almost the sole arbiter of the manner of delivering medical care to the underprivileged in his state. There is some vaguely outlined provision calling for the development and education of medical career officials. If this means the experimental setup of an educational system to train men who will later be the means of delivering *state medicine* to the people, then this should be frankly comprehended and our people must decide whether or not they eventually want pure state medicine. This in itself is an insidious wedge which leads to straight state medicine.

If the American people do not want straight state medicine, there seems little use in educating and developing a group of men to deliver it.

On the whole, the bill seems to have been introduced so as to be amended. It most certainly needs amendment upon amendment. Would it not be better to withdraw the bill, rewrite it with the aid of the medical profession, who must eventually administer it, and really make an attempt to accomplish some of the things that are enunciated in the parallelism of thought and of ideas of both the organized profession and the governmental agencies who took part in the various Inter-

departmental Committee conferences? What end have these so-called conferences had, if the Wagner bill is the outcome?

Most thoughtful people will concede that there is actual need of medical policy being determined by doctors. There is need for the adoption of adequate standards of care for the various groups in our national body politic. There is a strong desire everywhere to lower the expenditures of the Federal government in bringing health measures, and health agencies together in useful coordinated work, *where they are needed*—and who is to determine the medical needs of a community if not its doctors! There certainly seems also to be a need to correlate local community needs, and the distributional agencies for medical care in those same communities. This correlation should not be placed in the hands of a purely political group whose "weather eye" never loses sight of the effect of its decisions on the electorate, and its vote.

Whatever our individual opinions may be anent the five major proposals of the national health conference—and there is much in them that even we deem unnecessary and uncalled for, much that would entail an unjustifiable tax burden on an already overtaxed public—this particular Wagner health bill fails even to meet these propositions. It is wholly impractical, it is almost unworkable, it is certainly extremely vague, and absolutely unsuitable from our standpoint. If enacted into law, it will bring the medical profession into such difficulties that it will take decades to extricate itself from them. Particularly will it be difficult to evade the bureaucratic *interpretations* which must be made, perforce, because the bill is full of uncertain terms, and contains too many unprecedented tentative permissive clauses.

With all due respect to the senior Senator from New York, we would characterize the Wagner health bill as extremely *amateurish* did we not suspect that this veteran political strategist has purposely drawn it so vaguely that its passage through Congress would encounter the least amount of oppositional friction in its passage toward enactment. The program seems to be: meet opposition with vagueness, let decisions be made later. *Apres, moi, le deluge!*

The public concern for the health of the people is entitled to more than a good piece of political strategy in a health bill. The profession which will have to work under the bill, the governmental agencies which plan the measures and procedures under its permissive clauses, and the taxpaying public which will foot the bills to pay for it—all deserve a *precisely drawn bill*, so that all will know beforehand just what is being proposed, what it will deliver, who sits at the controls, and what it is going to cost.

It seems to us that it should be realized that now is not the time to write another blank check on the Treasury to be filled in, at will, by lay experimenters in health measures for the general public.

Editorial, *N. Y. S. J. of M.*, April 1, 1939

NEW LEGISLATION—1939

Senate Bill No. 27

An Act Requiring Prenatal Examination for Syphilis

Be it enacted by the Senate and House of Representatives of the State of Delaware in General Assembly met:

Section 1. Every physician attending a pregnant woman in Delaware during gestation shall, in the case of each woman so attended, take or cause to be taken a sample of blood of such woman at the time of first examination, and submit such sample to an approved laboratory for a standard serological test for syphilis. Every other person permitted by law to attend upon pregnant women in the State but not permitted by law to attend upon pregnant women in the State but not permitted by law to take blood tests, shall cause a sample of the blood of such pregnant woman to be taken by a duly licensed physician and submitted to an approved laboratory for a standard serological test for syphilis. The term "approved laboratory" means a laboratory approved for this purpose by the State Board of Health. A standard serological test for syphilis is one recognized as such by the State Board of Health. Such laboratory tests as are required by this Act shall be made on request without charge by the State Board of Health.

Section 2. In reporting every birth or stillbirth, physicians and others permitted to attend pregnancy cases and required to report

births, and stillbirths shall state on the birth certificate or stillbirth certificate, as the case may be, whether a blood test for syphilis has been made during such pregnancy upon a specimen of blood taken from the woman who bore the child for which a birth or stillbirth certificate is filed and, if made, the date when such test was made, and, if not made, the reason why such test was not made. In no event shall the birth certificate state the result of the test.

Section 3. This Act shall take effect immediately.

House Bill No. 143

An Act Regulating the Sale and Possession of Barbital and Other Hypnotic Drugs

Be it enacted by the Senate and House of Representatives of the State of Delaware in General Assembly met:

Section 1. No Barbital or any other hypnotic drug or somnifacient drug, defined herein, shall be sold at retail or dispensed to any person in the State of Delaware, except upon the written prescription of a duly authorized physician, dentist, or veterinarian, and no pharmacist shall dispense any such drug without affixing to the container in which the drug is sold or dispensed a label bearing the name and address of the pharmacist, the date compounded and the consecutive number of the prescription under which it is recorded in his prescription files, together with the name of the physician, dentist, or veterinarian prescribing it, and the directions for the use of the drug as given on said prescription of the physician, dentist, or veterinarian.

Section 2. No manufacturer, pharmacist, jobber or other dealer in drugs shall sell or have in his possession Barbital, or any other hypnotic or somnifacient drug, unless the container bears a label securely attached thereto stating conspicuously in printed words the specific name of the Barbital or other hypnotic or somnifacient drug, and the proportion or amount thereof. Such labels shall not be necessary when such a drug is dispensed by a pharmacist upon a prescription and the container is labeled in the manner described in Section 1.

Section 3. For the purposes of this act the term Barbital shall be held to mean and include, the salts or Barbituric Acid, also known as Malonylures, or any derivative or compound or any preparations or mixtures thereof containing more than ten grains to the avoirdupois or fluid ounce of the said substance. And the term "Other hypnotic or somnifacient drugs" shall be held to mean and include, Sulphon ethyl methane (trional) or Sulphonmethane (Sulphonal) or Diethyl-sulphone, Diethyl-methane (Tetronal) or Paraldehyde or any derivative or compound, or any preparation or mixture containing more than ten grains to the avoirdupois or fluid ounce of the said substances and Chloral or Chloral hydrates, or Chlorbutanol, or any compounds or mixtures thereof containing more than ten grains to the avoirdupois or fluid ounce of the said substances when such Chloral or Chloral hydrates or Chlorbutanol, or compounds or mixtures thereof are to be used internally.

Section 4. The provisions of this section shall apply to any of the above mentioned drugs or any derivatives or compounds or any mixtures or preparations thereof, as above set forth, whatever may be the name under or by which the same name be called or known.

Section 5. Every pharmacist, physician, dentist, veterinarian, licensed jobber, dispensing any of the heretofore mentioned drugs shall keep an accurate record of the name and address of the patient, the date and the name and quantity of the drug dispensed, as well as an accurate record of all renewals.

House Amendment to House Bill No. 143

AMEND House Bill No. 143 by adding a new section to said Bill to be known as Section 6 to read as follows:

Section 6. The term "physician" shall mean any duly licensed physician of any school of practice.

AMERICAN MEDICAL ASSOCIATION
Study of Medical Care
Report from the Medical Society of Delaware

The study, covering the state of Delaware, which has a population of approximately 250,000, was conducted by the Medical Economics Committee of the Medical Society of Delaware. It was assisted in the distribution and the collection of forms by the State Board of Health and the Wilmington Board of Health. The compilation of the data and the preparation of the summary were made under the direction of the secretary of the state medical society. The information obtained is believed to furnish the most pertinent facts regarding the availability or lack of medical care in this area.

The information and data are based on reports from 109 physicians, or 36 per cent of the 303 physicians in active practice. No replies were received from dentists, and only seven pharmacists returned their forms. The hospitals all cooperated in supplying information. There are nine general hospitals, including a contagious disease unit and a mental deficiency unit, one army hospital, one mental hospital, two tuberculosis hospitals, one preventorium and one state welfare home.

The health departments were very cooperative in furnishing information and data, and consequently the conclusions on the need and supply of medical care depends a great deal on their information. The Wilmington Board of Health furnishes medical services, laboratory diagnosis and sanitary supervision. The State Board of Health, with a component unit in each county, maintains records and vital statistics, makes laboratory tests and maintains sanitation supervision, maternal and child health supervision, communicable and venereal disease controls, tuberculosis sanatoriums, and dental hygiene and public health nurses. All schools, colleges, nurses and relief agencies also contributed valuable information to the Medical Economics Committee for this study.

The consensus of the physicians who returned the forms is that medical care is available to every one. Of 109 physicians supplying information only ten, or 9 per cent, reported that they knew of cases in which any type of medical care was not easily obtainable. Since the 109 physicians are located in all parts of the state, it can be assumed that their experiences are representative of all physicians in the state. Therefore approximately only twenty-seven of the total 303 active physicians in the state have observed inadequacies of any type of medical care.

The Medical Economics Committee's report on the specific needs for increased facilities for the distribution of medical care, and recommendations for services that should be expanded in order to make medical care more easily obtainable to certain low income groups, follow:

Delaware is a small, compact and conservative state, with a per capita wealth well ahead of most of the states: its terrain is practically level, the roads are excellent, and medical care can easily be reached. As a matter of fact, among the few instances reported of persons receiving no medical care, there must be a fair sprinkling of those who did not know how to secure such care and still another group who did not wish for care at the hands of the regular medical profession. However, by this statement it is not meant to imply that Delaware is a land of plenty, medically speaking, because certain facilities definitely need to be expanded and there are certain services which should be enlarged; among these are:

1. Increased facilities for negro tuberculous patients. A bill is now in the Legislature which, if passed, will appropriate $150,000 to provide sixty additional beds for this purpose.

2. An increase in beds available for negro maternity work is desirable, especially outside Wilmington. No program is at present outlined. Within the past year two hospitals in Wilmington have built new maternity wings, including a fairly adequate number of beds for negroes.

3. There is a need for more public health nurses and/or visiting nursing service, especially in rural New Castle county. The Levy Court of this county is being petitioned to provide funds for this purpose, as well as an additional county physician or physicians who perhaps will serve on a part-time basis.

4. The hospitals throughout the state need additional beds for general medical and surgical care despite the fact that their occupancy last year was approximately 60 to 65 per cent.

This is due to the fact that there are certain peaks of the load, during which time the most urgent cases can be admitted and the less urgent cases are placed on a waiting list.

5. The care of the psychiatric sick is limited to one institution, which serves the whole state and which has been the victim for many years of a vicious degree of overcrowding. Whatever remedy for this condition there may be must come from the Legislature, before which appropriation bills will be presented.

6. The mentally deficient are being cared for at a state colony accommodating some 468 patients. However, the lack of housing facilities and a sufficient budget prevents some 200 eligibles from being admitted. The Legislature is now conducting a special investigation of this institution and its needs.

7. The care of certan of the aged indigents and chronically ill is centralized in one state welfare home, which replaces the three county poor houses. This is a splendid institution but is already overcrowded, and relief is now being sought from the present Legislature.

8. The various clinics operated by the State Board of Health for venereal diseases, tuberculosis, well baby and maternal welfare are scattered throughout the state at strategic points, and this service will be expanded as, when and if the demand can be demonstrated.

9. Certain clinics, notably the birth control clinic, are being conducted by lay organizations, but the clinics so far established under these auspices are well managed and are staffed by the medical profession.

10. The care of the blind is arranged for by the Delaware Commission for the Blind, which does not operate its own clinic but which has not failed to provide adequate services through the various physicians and hospitals.

11. Care of the crippled has been given by the hospitals and medical profession and has seemed to be fairly adequate. Whatever deficiencies there may be today will be remedied within a year by a new hospital-school to be erected by the Nemours Foundation, which was endowed by the will of the late Mr. Alfred I. du Pont and which will be one of the leading orthopedic institutions in the country.

General Needs

The feeling throughout the profession is that physicians should be paid for services rendered to the indigent and near indigent. This introduces a question the answer for which is not apparent with certainty, but certain plans are in the making to provide for this feature. Wilmington has a group hospital service on the board of which the medical profession is adequately represented and which has been functioning for three years with satisfactinn to all concerned. It is proposed to extend this coverage to the counties as well as to the city and to include individual memberships in addition to the employed groups, which now make up the 13,000 members. In addition to this feature there is a surprisingly large general demand for medical expense indemnity insurance, and the Medical Economics Committee of the New Castle County Medical Society is at present working on this problem and will in due time propose to the society a plan for its adoption. It is fairly certain that if and when this plan is adopted in Wilmington it will soon thereafter become statewide in its operation.

Delaware has, in lieu of county commissioners, a Levy Court of each county, which makes appropriations for the maintenance of hospital beds for the indigent on a per diem basis. These appropriations are inadequate, the deficits being met from private sources. If the medical indemnity insurance plan succeeds, it may be proposed that the Levy Courts, together with appropriations from the state, buy and keep in force the insurance for indigents and near indigents, which may in the long run prove cheaper than the present system of appropriations if there are an equal number who need this service.

In addition to such medical expense indemnity insurance there should be set up at strategic points throughout the state some central authority whose duty it shall be to weed out the indigent and near indigent from those who are able to pay their sickness expense in full or in part.

Conclusion

From these statistical data and summaries it will be appreciated that the needs in Delaware are not as acute as they are in many other communities, but it will also appear that neither the profession nor the public is fully satisfied; to remedy these defects, adequate plans and proposals are already in the making. —*J. A. M. A.*, March 18, 1939.

MISCELLANEOUS

New York World's Fair Health Calendar

An elaborate calendar of special events and days will be celebrated at the New York World's Fair 1939 during the six months' period this summer. Leading organizations have scheduled a large number of days for the observance of health and medicine in the "World of Tomorrow." These include:

May 1—National Child Health Week (to May 8)
9—Dental Society of New York State Day
12—National Hospital Day
Nurses Day
16—American Medical Association Day
17—Red Cross Day
19—Tenth International Congress of Military Medicine and Pharmacy Day
31—State Medical Association Day
June 3—American Academy of Pediatrics Day
4—American Society for the Hard of Hearing Day
18—New York City Health Department Day
23—School Health Day
27—County Medical Association Day
October 21—National Health Day

The American Physicians' Art Association

The American Physicians' Art Association, composed of members in the United States, Canada, and Hawaii, will hold its second art exhibit in the City Art Museum of St. Louis, May 14-20, 1939, during the annual session of the American Medical Association. Art pieces will be accepted for this art show in the following classifications: (1) oils both (a) portrait and (b) landscape; (2) water colors; (3) sculpture; (4) photographic art; (5) etchings; (6) ceramics; (7) pastels; (8) charcoal drawings; (9) bookbinding; (10) wood carving; (11) metal work (jewelry). Practically all pieces sent in will be accepted. There will be over 60 valuable prize awards. For details of membership in this Association and rules of the exhibit, write to Max Thorek, M. D., secretary, 850 Irving Park Blvd., Chicago, Ill., or F. H. Redewill, M. D., president, 521-536 Flood Bldg., San Francisco, Calif.

AGAIN WAGNER

"Wagner Act minor changes will probably be brought about in the Wagner Act when Congress reconvenes. One of the changes will be the clearing up of language that is now *uncomprehensible*. It will be made to define more clearly the responsibility of employers."

The italics are ours, in this excerpt from the *Washington News Letter*, of October 17, 1938, by ex-Congressman William F. Allen, of Delaware. Mr. Allen might have added that while nobody can understand the language of Washington, everybody sees through its purposes—and the view is not reassuring at least, medically speaking.

DR. MORRIS TO LEAVE

(*Concluded from Page* 62)

M. D. at Johns Hopkins in 1933. In the interims he accumulated experience as a journalist and magazine editor on the Springfield (Massachusetts) Republican, the Cleveland Plain Dealer, and on Light, the magazine of the General Electric Company. He specialized in the study and treatment of childhood-diseases, doing post-graduate medical work in pediatrics at Johns Hopkins and at the Henry Ford Hospital, Detroit.

His first wife died in 1936. In 1938 he married Miss Dorothy Wells of Dover. He has two daughters.

Dr. Morris takes to his new position the best wishes of the Delaware profession.

OBITUARY

MARTIN W. BARR, M. D.

Dr. Martin W. Barr, of Middletown, Del., former superintendent of the Elwyn Training School near Media, Pa., died December 25, 1938, aged 78.

Dr. Barr was born in Wilmington, Del., February 17, 1860, a son of Joseph and Hannah Justice Barr. His early education consisted of attending a private school in Claymont, Del., later Friends' School in Wilmington, then St. Ann's school in Middletown, following which he entered Shortledge Academy in Media. It was while at the Shortledge Academy that Dr. Barr made his first contacts with Elwyn. He was graduate from the University of Pennsylvania Medical School in 1884 and began the practice of medi-

cine in Middletown, where his uncle and grandfather had practiced in their day.

An early recollection of Dr. Barr's was of Camp Douglas, Ill., where his father was stationed as Judge Advocate. Another early recollection was traveling east with his father to attend the funeral of Abraham Lincoln.

Dr. Barr accepted the position of second assistant at Elwyn in September, 1884. The superintendent decided that his assistant should have a wider knowledge of psychiatry and sent Dr. Barr to the Harrisburg State Hospital, where he remained approximately one year. Following this he returned to Elwyn for three years, and then went to the Channing Hospital in Boston for further postgraduate study. While at the Channing Hospital he went to London to study at the Royal College of Surgeons in London, and later went to Paris to work under Dr. Bourneville. Returning from abroad, Dr. Barr took up his duties as first assistant at Elwyn, and on the death of Dr. Kerlin in 1893 he was elected chief physician. He was devoted to the children of Elwyn, which devotion was returned by them in full measure.

It would be almost impossible to review all of the things accomplished at Elwyn under Dr. Barr's superintendency, to describe in detail the honors he received, to list the meetings and organizations he addressed, or to adequately evaluate his writings. He published two books on mental deficiency, however, the first in 1904, *Mental Defectives,* and the second, *Types of Mental Defectives,* in 1920.

Among the honors received by Dr. Barr were the presidency of the Association of Medical Officers of American Institutions for Idiotic and Feeble-Minded Children (now known as the American Association on Mental Deficiency); his call to lecture in Japan and China in 1920-21, where he was given the Japanese insignia, the greatest honor that country can give a foreigner; and, a request from the Pope for an interview.

He was the author of the first bill for sterilization of the mentally deficient. His bill was passed by the Pennsylvania Legislature in 1905, but was vetoed by Governor Pennypacker. He spoke in many states to further such legislation.

Dr. Barr decided to retire in 1924, and did toward the end of that year. He was succeeded by Dr. William M. Fielding, who resigned after a little over a year. In February 1926, Dr. Barr was recalled as chief physician. He again decided to retire in April, 1930, when he returned to his old home in Middletown, where he died.

Dr. Barr was unmarried.

—*Pa. M. J.*, April, 1939

BOOK REVIEWS

Clinical Gastroenterology. By Horace Wendell Soper, M. D. Pp. 314, with 212 illustrations. Cloth. Price $6.00. St. Louis: C. V. Mosby Company, 1939.

Dr. Soper's book is unusual in that it is profusely illustrated with case histories and x-ray films illustrating the exact extent of the pathology, and also showing, in most cases, results after treatment.

The chapter on peptic ulcer, giving detailed management, should prove invaluable to the general practitioner. Here he gives a brief resume of various methods of medical treatment, concluding with his own egg and milk emulsion treatment. He sums the whole subject up by stating, "The character and quality of daily digested food spells success or failure of the healing of ulcers."

Liver and gall bladder disease is gone into very thoroughly, and here also are shown many rare x-ray films.

About one-third of the volume deals with the colon and constipation. Here he clearly differentiates pathologic entities from the various functional disturbances, such as spastic contractures, etc., and gives detailed information as to the management of such cases.

The chapter on proctosigmoidoscopy, while short, contains much detail and gives the clinician valuable information on this important examination.

Dr. Soper has covered clinical gastroenterology in a masterly manner, and we heartily recommend his book.

Sleep, Your Life's One Third. By Maurice Chideckel, M. D. Pp. 183. Cloth. Price, $2.00. New York: Saravan House, 1939.

Dr. Chideckel has written a very complete summary about sleep, for lay readers. This

book, like his others, is quite readable; the chapters are unusually short and the style is entertaining. The evidence of hasty proofreading (an omitted word here and there) should be removed in the next edition. We recommend the book to the laity.

The Vaginal Diaphragm. By Le Mon Clark, M. D. Pp. 107, with 53 illustrations. Cloth. Price, $2.00. St. Louis: C. V. Mosby Company, 1939.

This is an authoritative discussion of one method of contraception. The text is clearly written, and the illustrations add emphasis. The book also contains much good advice to the newlywed.

Concepts and Problems of Psychotherapy. By Leland E. Hinsie, M. D., Professor of Clinical Psychiatry, Columbia University. Pp. 199. Cloth. Price, $2.75. New York: Columbia University Press, 1937.

This book is a clear and concise description of the different types of psychotherapy now in vogue. The author shows similarly the value of the methods used, and the applicability of various methods to certain types of patients. He shows the limitations of psychoanalysis in its present status, but also his full appreciation of its value as a therapeutic measure in selected cases. He definitely understands a considerable amount of research and investigation is still necessary before it is possible to determine the value of various therapeutic measures in the functional mental disorders. He appreciates the fact that spontaneous recovery does occur, that many cases of maladjustment do not come to the psychiatrist, and that statistical reports for this reason are subject to considerable error. It is a book that should be read by everyone who is interested in mental abnormality of a non-organic nature, and is of extreme value to any physician or social worker who deals with patients who are suffering from such.